

# **Exhibit “D”**

## Exhibit "4"

Affidavit of Fraudulent Medical Services, Referrals and Prescriptions

STATE OF NEW YORK    }  
                                       } ss.:  
 COUNTY OF                }

**Arkam Rehman, M.D.**, being duly sworn, hereby states the following:

1. I am a physician who is licensed to practice medicine in the State of New York under license number 298627. I have been licensed as a physician in the State of New York since April 12, 2019. I am double Board Certified in pain management and physiatry. I am also the owner of Apex Medical, P.C. (Apex), a medical office that conducts, among other testing and/or treatment, Evaluations and Management (E&M) services and Shockwave Therapy. My National Provider Identifier (NPI) number is 1013920602 and my Drug Enforcement Agency (DEA) number is FR8865000.

2. This affidavit is being provided to demonstrate the fraudulent nature of certain medical services, diagnostic tests, referrals, and prescriptions that have been attributed to me personally, my NPI number, my DEA number and/or Apex. As will be demonstrated below, since I have been a practicing physician in the State of New York I did not issue or authorize the certain prescriptions for drug screening, toxicology services, prescription medications, prescription creams, prescription gels, diagnostic test(s), radiological test(s) or otherwise in connection with the prescriptions all as demonstrated in paragraphs 4, 6, 9, 12, 15, 18, 21, 24, 27, 31, 33, 36, 39, 42, 45, 48, 51, 54, 57, 59, 62, 65, 68, 71, 74, 77, 80, 83, 86, 89, 92 and 95 noted below.

3. During the year 2020, my medical office provided, among other testing and/or treatments, E&M services, and Shockwave Therapy at two locations in Brooklyn, New York: 3027 Avenue V, Brooklyn, New York and 632 Utica Avenue, Brooklyn, New York. My role at these two locations was limited in scope. In or about the spring of 2021, I learned for the first time that my name and credentials were utilized by certain unknown individuals as part of a scheme to dispense medication, durable medical equipment and prescribe tests and procedures as noted below. I did not prescribe or authorize a prescription for drug screening, toxicology services, prescription medications, prescription creams, prescription gels, diagnostic testing, radiological testing or otherwise for the certain prescriptions as demonstrated in paragraphs 4, 6, 9, 12, 15, 18,

21, 24, 27, 31, 33, 36, 39, 42, 45, 48, 51, 54, 57, 59, 62, 65, 68, 71, 74, 77, 80, 83, 86, 89, 92 and 95 below. A representative example of some of the prescriptions that are fraudulent in nature are shown below. The fact that a prescription is not specifically referenced below does not, and should not, be an indication that it is legitimate. As demonstrated below, the prescriptions that were allegedly prescribed by me at either 3027 Avenue V, Brooklyn, New York or 632 Utica Avenue, Brooklyn, New York are fraudulent in nature and are not legitimate.

**S&K Pharmacy – Volfi Inc.**

4. I did not prescribe nor authorize the prescription for any medication, creams, patches, or ointments as allegedly provided by S&K Pharmacy a/k/a Volfi INC as indicated below:

**LEADER<sup>TM</sup>** *Telephone Prescription*

Kinray Generic Customer Service • Phone: 347-438-2884

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Pharmacist \_\_\_\_\_ Time 3:00  
 Phone# \_\_\_\_\_ Refill 7

**Rx**

*Lidotta patch*  
*#60*

*Apr 1 patch to skin*  
*BID*

*Spec to*  
*MD*

This Prescription Will Be Filled Generically Unless  
 Prescriber Writes "d.w." In The Box Below

☐

Dispense As Written

Dr. Rehman A-Kam Tel: (907) 292-  
1 2765  
 Address \_\_\_\_\_  
 Lic. No. 5 DEA# \_\_\_\_\_

Not A Physician Pad • Pharmacy Use Only

5. The above prescription in paragraph 4 is a representative example and is fraudulent in nature as I never prescribed the item to be dispensed.

6. The following prescription is also fraudulent in nature as I did not sign the prescription, I did not prescribe or request that the following medication be given to the patient, nor did I agree with the Statement of Medical Necessity contained within the prescription:



This facsimile transmission is intended to be delivered to the named addressee and may contain information that is confidential, privileged and proprietary or exempt from disclosure under applicable law, if it is received by a name other than the named addressee, please destroy.



Name: [REDACTED]		DOB: [REDACTED]	DOA: [REDACTED]
Address: [REDACTED]			
Home Phone: [REDACTED]			
Medication Allergies: [REDACTED]			
Insurance: [REDACTED]			
Carrier/Claim #: [REDACTED]			
<b>Ibuprofen Tablets:</b> 200mg 100mg 600mg Dose: 30 60 90 120	<b>Celebrex Tablets:</b> 100mg 200mg 400mg Dose: 30 60 90	<b>Naproxen Tablets:</b> 250mg 500mg 750mg Dose: 30 60	<b>Cyclobenzaprine Tablets:</b> 10mg 20mg 30mg Dose: 30 60 90
<b>Diclofenac Sodium Gel 1%:</b> 100g 250g 500g	<b>Lidocaine Ointment 5%:</b> 100g 200g 300g 400g	<b>Lidocaine Patch:</b> Lidocaine 4.5% Methyl 5% Dose: 60 90	<b>Pain Relief 2%:</b> 100g 250g 500g
<b>Zinc Capsules (NSAID):</b> 100mg 250mg 500mg Dose: 100 capsules	<b>Topiramate:</b> 150mg 225mg 300mg 400mg	<b>Symptomatic Tablets:</b> 100mg 250mg 500mg Dose: 9 12	<b>Other:</b>
<b>Prescriber Information:</b> Doctor's Name: <u>Akram Rehman</u> Address: <u>3027 ave V Brooklyn NY 11229</u> NPI#: <u>1013920602</u> License#: <u>298627</u>			
<b>Statement of Medical Necessity:</b> Side effects associated with oral administration can often be avoided when medications are used topically. When medications are administered topically, they are not absorbed through the gastrointestinal system and do not undergo first pass hepatic metabolism. Topical creams/patches are in conjunction with lower doses of oral medications to prevent dependence and side effects of oral medications.			
Physician Signature: <u>Akram</u>		Date: <u>1/27/21</u>	

7. The above prescription in paragraph 6 is a representative example and is fraudulent in nature as I never prescribed the item to be dispensed nor did I sign or authorize the prescription.

8. The above-mentioned prescription in paragraph 6 presented by S&K Pharmacy a/k/a Volfi Inc that is/are alleged to have been prescribed by me is/are fraudulent in nature as I never prescribed or authorized the item to be dispensed.

#### V V X, Inc

9. I did not prescribe nor authorize the prescription for any durable medical equipment as allegedly provided by V V X, Inc. as indicated below:



Rx/Prescription

DME Order Form

Patient Name: [REDACTED]

POA: \_\_\_\_\_

DOB: \_\_\_\_\_

\_\_\_\_ Orthopedic Lumbar Cushion

\_\_\_\_ Electrodes (4 Leads)

\_\_\_\_ Thermal Heating Pads

\_\_\_\_ Massager (w/Infrared Lamp)

\_\_\_\_ Abdominal Support

\_\_\_\_ Water Therapy System w/Pump

\_\_\_\_ Dry Pressure Mattress

\_\_\_\_ Back Support TLSO

\_\_\_\_ Bed Boards

\_\_\_\_ Infrared Lamp

\_\_\_\_ Orthopedic Positioning Seat

\_\_\_\_ Cervical Collar

\_\_\_\_ Cervical Cover (2 piece)

\_\_\_\_ Orthopedic Cervical Pillow

\_\_\_\_ Cane Adjustable

\_\_\_\_ Walker

\_\_\_\_ Walker (w/Wheels)

\_\_\_\_ Back Support TLSO

\_\_\_\_ Crutches Adjustable

\_\_\_\_ Cervical Posture Pump

\_\_\_\_ Shoulder Support

\_\_\_\_ Knee Brace KO Adjustable Hinge

\_\_\_\_ Wrist Support

\_\_\_\_ Lumber Support LSO

\_\_\_\_ Elbow Support

OTHER: \_\_\_\_\_

\_\_\_\_ Ankle Support

\_\_\_\_ Knee Support

Physician's Signature: [Signature] NP-RNPI #: 1013920602

Physician's Name: Dr Arkam Rehman

Physician's Address: 632 Utica Ave Brooklyn NY 11203

Today's Date: 12/6/20

10. The above prescription in paragraph 9 is a representative example and is fraudulent in nature as I never prescribed the item to be dispensed nor did I sign or authorize the prescription.

11. The above prescription in paragraph 9 presented by V V X, Inc. that is/are alleged to have been prescribed by me is/are fraudulent in nature as I never prescribed or authorized the item to be dispensed.

**Top Choice Pharmacy Corp. – Top Choice Rx**

12. I did not prescribe nor authorize the prescription for any medication, creams, patches, or ointments as allegedly provided by Top Choice Pharmacy Corp. – Top Choice Rx as indicated below. The following prescription is also fraudulent in nature as I did not sign the prescription, I did not prescribe or request that the following medication be given to the patient, nor did I agree with the Statement of Medical Necessity contained within the prescription:

This document transmission is intended to be delivered to the named addressee and any other information on this confidential privileged and proprietary or exempt from disclosure under applicable law, if it is received by a name other than the named addressee, please destroy.

**PHARMACY**

Name: [REDACTED] DOB: [REDACTED] POA: [REDACTED]

Address: [REDACTED]

Home Phone: [REDACTED] Cell: [REDACTED] Fax: [REDACTED]

Medication Allergies: [REDACTED]

Insurance: [REDACTED]

Current Claim #: [REDACTED]

History of Tests: [REDACTED]

Strength: [REDACTED]

Directions: [REDACTED]

Discontinue Substitution: [REDACTED]

Time Capsules: [REDACTED]

Strength: [REDACTED]

Directions: [REDACTED]

Prescription Information:

Doctor Name: [REDACTED]

Address: [REDACTED]

NPI#: [REDACTED]

Signature of Medical Practitioner: [REDACTED]

Physician Signature: [REDACTED]

Date: 8/20/20

13. The above prescription in paragraph 12 is a representative example and is fraudulent in nature as I never prescribed the item to be dispensed nor did I sign or authorize the prescription.

14. The above-mentioned prescription in paragraph 12 presented by Top Choice Pharmacy Corp. – Top Choice Rx that is/are alleged to have been prescribed by me is/are fraudulent in nature as I never prescribed or authorized the item to be dispensed.

#### TopLab

15. I did not prescribe nor authorize the prescription for any drug tests, drug screening or drug confirmations as allegedly provided by TopLab as indicated below:



67-71 EAST WILLOW STREET  
MILBURN, NJ 07041

## Laboratory Report

**Final Copy**  
**Confidential – Laboratory Report**

Lab Director: Ayad Mudarris  
Tel#: (877)355-3580  
Fax#: (866)899-3995  
CLIA Number: 3102135687

### Client Information:

Client: Medical Office of Brooklyn  
3027 Avenue V  
BROOKLYN, NY 11229  
Requesting Physician:  
Rehman, Arkam

### Patient Information:

Patient Name: [REDACTED]  
Patient ID: P9948089  
Date of Birth: 10/26/1987 (33 years)  
Male/Female: Male  
Fasting: NO

### Sample Information:

Lab Sample ID: 2010220026  
Collected: 10/21/2020 06:08 AM  
Received: 10/22/2020 06:08 AM  
Reported: 10/23/2020 01:37 PM

**PRESCRIBED MEDICATION:**



67-71 EAST WILLOW STREET  
MILBURN, NJ 07041

## Laboratory Report

**Final Copy**  
**Confidential – Laboratory Report**

Lab Director: Ayad Mudarris  
Tel#: (877)355-3580  
Fax#: (866)899-3995  
CLIA Number: 3102135687

### Client Information:

Client: Medical Office of Brooklyn  
3027 Avenue V  
BROOKLYN, NY 11229  
Requesting Physician:  
Rehman, Arkam

### Patient Information:

Patient Name: [REDACTED]  
Patient ID: P9958410  
Date of Birth: 9/6/1999 (21 years)  
Male/Female: Female  
Fasting: NO

### Sample Information:

Lab Sample ID: 2010210015  
Collected: 10/20/2020 04:51 AM  
Received: 10/21/2020 04:51 AM  
Reported: 11/26/2020 12:43 PM

**PRESCRIBED MEDICATION:**

16. The drug screening reports referenced above in paragraph 15 are a representative example and are fraudulent in nature as I never requested, prescribed, or ordered any drug tests, drug screenings or drug confirmations.

17. The above-mentioned prescriptions in paragraph 15 presented by TobLab claiming that I ordered a drug test, drug screening or drug confirmation alleged to have been requested, prescribed, or ordered by me is/are fraudulent in nature as I never requested, prescribed, or ordered or authorized the test.

**[The remainder of this page is intentionally left blank]**

TMVQS. Corp DBA Trinity Pharmacy

18. I did not prescribe nor authorize the prescription for any medication, creams, patches, or ointments as allegedly provided by TMVQS. Corp DBA Trinity Pharmacy as indicated below. The following prescription is also fraudulent in nature as I did not sign the prescription, I did not prescribe or request that the following medication be given to the patient:

<b>PRESCRIPTION ORDER FORM</b>		THIS FACSIMILE TRANSMISSION IS INTENDED TO BE DELIVERED TO THE NAMED ADDRESSEE AND MAY CONTAIN INFORMATION THAT IS CONFIDENTIAL, PRIVILEGED AND PROPRIETARY OR EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAW. IF IT IS RECEIVED BY ANYONE OTHER THAN THE NAMED ADDRESSEE, PLEASE CONTACT US AND DESTROY.	
NAME: [REDACTED]		DOA: / /	
ADDRESS: _____		CITY: _____ STATE: _____ ZIP: _____	
EMAIL: _____			
HOME PHONE: _____		CELL PHONE: _____	
INSURANCE: _____			
CLAIM/CARRIER: _____		POLICY/WCB#: _____	
ICD 10/BODY PARTS: _____			
<b>SOMNININ 2MG-50MG-100MG-10MG-50MG CAPSULE</b> SIG: TAKE 1-2 CAPSULES BY MOUTH 30 MINUTES BEFORE BEDTIME DISP: 30 60 90 REFILLS: 1		OTHER: _____ SIG: _____ DISP: 30 60 90 REFILLS: _____	
<b>PRESCRIBER INFORMATION</b> NAME: <u>A. Rehmes</u> ADDRESS: <u>3027 Ave V</u> CITY: <u>Brooklyn</u> STATE: <u>NY</u> ZIP: <u>11229</u> NPI#: <u>1013920602</u> LIC# <u>298627</u>		RLS-64371 2002 10/05/01 J.S. DOB: 05/19/90 LARK, COURTNEY [NOI] 70 E 20TH ST BROOKLYN NY 11219 RE: SO. SOMNININ CAP 100-50-1 BY ALPHEA J. LARK (Prescribed Lark) DEA# 16-08-0756-01 Copy: 21/01 10/24/01 11/23/01 Add#	
PHYSICIAN SIGNATURE: <u>A. Rehmes</u>		DATE: <u>1/11/21</u>	

19. The above prescription order form in paragraph 18 is a representative example and is fraudulent in nature as I never prescribed the item to be dispensed nor did I sign or authorize the prescription.

20. The above-mentioned prescription in paragraph 18 presented by TMVQS. Corp DBA Trinity Pharmacy that is/are alleged to have been prescribed by me is/are fraudulent in nature as I never prescribed or authorized the item to be dispensed.





Time to Care Pharmacy Inc.

24. I did not prescribe nor authorize the prescription for any medication, creams, patches, or ointments as allegedly provided by Time to Care Pharmacy, Inc. as indicated below. The following prescriptions are also fraudulent in nature as I did not sign the prescription, I did not prescribe or request that the following medication be given to the patient:

Time to Care Pharmacy, INC.  
248-47 Jericho TPKE Bellrose, NY 11426  
Phone: (929)207-5300 Fax: (929)207-5400 1/20/2021 10:22:40AM

Rx Pres: Arkan Rehman	Ord Date: 01/18/2021
3027 avenue V	NPI: 1013920602
brooklyn, ny 11229	LIC#: 298627
Phone: (347)702-9725	DEA#: FR8865000
Fax: (904)292-2666	SPI#

Patient: [REDACTED] 

DOB: [REDACTED] Gender: F Rst#: 69702

Address: 1410 ROCKAWAY PARKWAY BROOKLYN, NY 11236

Phone: (646)573-4789 Qty Ord: 60.000

Qty: 60.00 Days: 30 Refills: 0 PH/TH/AJ Class: 0

Drug: NAPROXEN SODIUM 550MG TAB

Sig: TAKE ONE TABLET BY MOUTH TWICE A DAY AFTER MEALS

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This Prescription Will be Filled Generically Unless Prescriber Writes "DAW" in the Box ☐ N Dispense As Written

Facsimile Rx

Time to Care Pharmacy, INC.  
248-47 Jericho TPKE Bellrose, NY 11426  
Phone: (929)207-5300 Fax: (929)207-5400 1/20/2021 10:22:40AM

Rx Pres: Arkan Rehman	Ord Date: 01/18/2021
3027 avenue V	NPI: 1013920602
brooklyn, ny 11229	LIC#: 298627
Phone: (347)702-9725	DEA#: FR8865000
Fax: (904)292-2666	SPI#

Patient: [REDACTED] 

DOB: [REDACTED] Gender: F Rst#: 69703

Address: 1410 ROCKAWAY PARKWAY BROOKLYN, NY 11236

Phone: (646)573-4789 Qty Ord: 200.000

Qty: 200.00 Days: 30 Refills: 0 PH/TH/AJ Class: 0

Drug: DICLOFENAC SODIUM 3% OEL

Sig: APPLY TO AFFECTED AREA TWICE A DAY

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This Prescription Will be Filled Generically Unless Prescriber Writes "DAW" in the Box ☐ N Dispense As Written

Facsimile Rx

25. The above prescriptions in paragraph 24 are a representative example and are fraudulent in nature as I never prescribed the items to be dispensed nor did I sign or authorize the prescription.

26. To the best of my recollection the above-mentioned prescription in paragraph 24 presented by Time to Care Pharmacy, Inc. Rx that is/are alleged to have been prescribed by me



is/are fraudulent in nature as I never prescribed or authorized the item to be dispensed.

### Simply DME LLC

27. I did not prescribe nor authorize the prescription for any durable medical equipment as allegedly provided by Simply DME LLC as indicated below. The following prescription is also fraudulent in nature as I did not sign the prescription, I did not prescribe or request that the following medication be given to the patient, nor did I agree with the Medical Necessity Statement contained within the prescription:

**DURABLE MEDICAL EQUIPMENT PRESCRIPTION ORDER FORM**

Patient Name: [REDACTED]

Insurance Type: Worker's Comp ☒ No Fee ☐ Commercial ☐ Medicare ☐

DX Code: \_\_\_\_\_

Insurance: Liberty Mutual

Date of Accident: 6/3/2020 Date of Surgery: \_\_\_\_\_

<b>GAMERREADY</b> Duration: <input type="checkbox"/> 2-3 weeks <input type="checkbox"/> 3-4 weeks <input type="checkbox"/> 4-5 weeks <input type="checkbox"/> 6-8 weeks <input type="checkbox"/> Other: _____	<b>HOMEBASED ULTRASOUND THERAPY</b> <input checked="" type="checkbox"/> PainShield <input type="checkbox"/> Remotort <input type="checkbox"/> 2-3 weeks <input type="checkbox"/> 2-4 weeks <input type="checkbox"/> Other: _____	<b>BRACING</b> <input type="checkbox"/> ROM Hug w/ knee brace <input type="checkbox"/> Shoulder Sling <input type="checkbox"/> Post-Op Elbow Ankle <input type="checkbox"/> Rigid Lumbar Support <input type="checkbox"/> Breast <input type="checkbox"/> Waist Brace <input type="checkbox"/> Post-Op Knee brace <input type="checkbox"/> Cam Walker Boot <input type="checkbox"/> short <input type="checkbox"/> tall
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**Muscle Issues**  
☐ M52.83 - Muscle Spasm  
☐ M60.308 - Diseases of the neuromuscular system and connective tissue  
☐ M60.303 - Disorders of muscles

**Contracture of Joint**  
☐ M24.80 - Contracture, unspecified joint  
☐ M62.4 - Contracture of muscle

**Pain in Upper and Lower Extremities**  
☐ M79.609 - Pain in unspecified lower leg  
☐ M25.561.2.9 - pain in knee (right, left, unspecified)  
☐ M25.571.2.9 - pain in ankle and foot (right, left, unspecified)  
☒ M25.511.2.9 - pain in shoulder (right, left, unspecified)  
☐ M25.502.2.9 - pain in elbow (right, left, unspecified)  
☐ M25.551.2.9 - pain in hip (right, left, unspecified)

**Medical Necessity Statement**  
 I am prescribing PainShield MD as a home-based therapy to be an adjunct therapy to a home-based therapeutic exercise program to help reduce pain, relieve muscle spasms and joint contractures, and induce soft-tissue healing. The low-intensity ultrasound machine (LITUM) passive therapy will assist the patient to self-manage their pain that occurs in the lower and upper extremities, and spinal cord. In addition, the device has demonstrated efficacy with muscle spasm and joint contracture conditions. The patient has no contraindications to LITUM and the LITUM is designed to be applied to the skin to relieve pain and induce soft tissue healing. In addition, the secondary effect of the LITUM has been attributed to a reduction in opioid prescribing as well as weaning patients off narcotic based prescriptions.

**Support Information**  
 At the CMS HCPCS Public Meeting, "the PainShield MD is indicated for the treatment of selected medical conditions such as pain, relief, muscle spasms and joint contractures". Effective 1/1/2020, the PainShield device is not considered durable and has been recommended for \_\_\_\_\_.

**Signature**  
 Patient Signature: Joseph Willis Date: 11/10/2020  
 Physician Signature: ARKAM Pehlivan Date: 9/6/2020  
 Printed Physician Name: ARKAM Pehlivan NPI: 10139310602

28. The above prescription order form in paragraph 27 is a representative example and is fraudulent in nature as I never prescribed the items to be dispensed nor did I sign or authorize the prescription.

29. The above-mentioned prescription in paragraph 27 presented by Simply DME LLC that is/are alleged to have been prescribed by me is/are fraudulent in nature as I never knowingly prescribed or authorized the item to be dispensed.

S&K Warbasse Pharmacy Inc.

31. I did not prescribe nor authorize the prescription for any medication, creams, patches, or ointments as allegedly provided by S&K Warbasse Pharmacy Inc. as indicated below. The following prescriptions are also fraudulent in nature as I did not sign the prescription, I did not prescribe or request that the following medication be given to the patient:

**LEADER<sup>TM</sup>** *Telephone Prescription*

---

Name [REDACTED] Age 12/1/00  
 Address [REDACTED] Date 12/1/00  
 Pharmacist [REDACTED] Time [REDACTED]  
 Phone# [REDACTED] Refill 0

**Rx** Lidothol 4.5-5% | pad  
 AP 1 patch BID  
 #60

This Prescription Will Be Filled Generically Unless  
 Prescriber Writes 'd a w' In The Box Below

Dispense As Written


Dr. Rehman, Arkam Tel: \_\_\_\_\_  
 Address \_\_\_\_\_  
 Lic. No. \_\_\_\_\_ DEA# \_\_\_\_\_

Not A Physician Pad • Pharmacy Use Only

32. The above prescription in paragraph 31 is a representative example and is fraudulent in nature as I never prescribed the item to be dispensed.

33. The following prescription below is also fraudulent in nature as I did not sign the

prescription, I did not prescribe or request that the following medication be given to the patient, nor did I agree with the Statement of Medical Necessity contained within the prescription:


 This facsimile transmission is intended to be delivered to the named address and may contain information that is confidential, privileged and proprietary or exempt from disclosure under applicable law, if it is received by a none other than the named addressee, please destroy.

**PHARMACY**

Name: [REDACTED]		DOB: [REDACTED]	DOA: [REDACTED]
Address: [REDACTED]			
Home Phone: [REDACTED]			
Medication Allergies: [REDACTED]			
Insurance: [REDACTED]			
Carrier/Claim #: [REDACTED]			

<b>Ibuprofen Tablets:</b> Strength: 600mg, 800mg Disp: 30, 60, 90, 120	<b>Celebrex Tablets:</b> Strength: 200mg, 400mg Disp: 30, 60, 90	<b>Naproxen Tablets:</b> Strength: 200mg, 400mg Disp: 30, 60	<b>Cyclobenzaprine Tablets:</b> Strength: 10mg Disp: 30, 60, 90
<b>Diclofenac Sodium Gel 1%:</b> Disp: 200gms, 250gms	<b>Lidocaine Ointment 5%:</b> Disp: 100gms, 200gms, 250gms	<b>Lidolol Patch:</b> Lidocaine 4.5% Methylol 5% Disp: 60, 90	<b>Pemisaide 2%:</b> Disp: 112
<b>Zinc Oxide Cream (NSAID):</b> Strength: 2.5gms Disp: 100gms	<b>Tigecycline:</b> Disp: 25mg, 50mg, 100mg	<b>Sunitinipatin Tablets:</b> Strength: 25mg, 50mg Disp: 30, 60	Other:

Prescriber Information:

Doctor Name: Herom Rehman

Address: 3027 ave V Brooklyn NY 11229

NPI#: 1013920602 License#: 298627

Statement of Medical Necessity:

Side effects associated with oral administration can often be avoided when medications are used topically. When medications are administered topically, they are not absorbed through the gastrointestinal system and do not undergo first pass hepatic metabolism. Topical creams/patches are in conjunction with lower doses of oral medications to prevent dependence and side effects of oral medications.

Physician Signature: [Signature] Date: 1/27/21

34. The above prescription order form in paragraph 33 is a representative example and is fraudulent in nature as I never prescribed the items to be dispensed nor did I sign or authorize the prescription.

35. The above-mentioned prescriptions in paragraphs 31 and 33 presented by S&K Warbasse Pharmacy Inc. that is/are alleged to have been prescribed by me is/are fraudulent in nature as I never prescribed or authorized the item to be dispensed.

RX Masters, Inc.

36. I did not prescribe nor authorize the prescription for any medication, creams, patches, or ointments as allegedly provided by RX Masters, Inc as indicated below. The following prescription is also fraudulent in nature as I did not sign the prescription, I did not prescribe or request that the following medication be given to the patient:

**Rx Masters Inc.**

1437 Webster Ave

Brooklyn, NY 11246

Phone: (718)293-0800 Fax: (718)293-0810 9/24/2020 2:23:13PM

Rx Presc: ARKAM REHMAN		Ord Date: 07/18/2020
3027 AVE Y		NPI: 1013930602
BROOKLYN, NY 11229		LIC: 298627
Phone: (347)702-9725 Fax:		DEA: FR8865000
Patient: [REDACTED]		SPIN
DOB: [REDACTED]	Gender: M	Rx#: 570490
Address: 9302 RIDGE BLVD NSE		BROOKLYN, NY 11209
Phone: (347)335-8143	Qty Ord: 200.000	
Qty: 200.00	Days: 30	Refills: 0
	PH/TH: RM	Class: 0
Drug: DICLOFENAC SODIUM 3% GEL		
Sig: APPLY TO AFFECTED AREAS THREE TIMES A DAY AS DIRECTED		
Signature: _____		Date: _____
This Prescription Will be Filled Generically Unless Prescriber Writes "DAW" in the Box		<input type="checkbox"/> N Dispense As Written

Telephone Rx

Rx#: 570490



37. The above prescription in paragraph 36 is a representative example and is fraudulent in nature as I never prescribed the items to be dispensed nor did I sign or authorize the prescription.

38. To the best of my recollection, the above-mentioned prescription in paragraph 36 presented by RX Masters, Inc. that is/are alleged to have been prescribed by me is/are fraudulent in nature as I never prescribed or authorized the item to be dispensed.



Rosar Medical Equipment Corp.

39. I did not prescribe nor authorize the prescription for any durable medical equipment as allegedly provided by Rosar Medical Equipment Corp. as indicated below. The following prescription is also fraudulent in nature as I did not sign the prescription, I did not prescribe or request that the following medication be given to the patient, nor did I agree with the Letter of Medical Necessity contained within the prescription:

*Specialists In Orthopedic & Durable Medical Rental Equipment*  
 Please complete the information below and send this form along with notes related to the relevant medical insurance information to: UNION MEDICAL GROUP, INC. 1000 10th Avenue, Suite 1000

Patient Name: [REDACTED] Rx Date: 10-11-20  
 Patient Address: [REDACTED] Patient Tel: [REDACTED]

Diagnosis: M23.94 - Knee Injury M59.01 - Segmental And Somato Dysfunction Of Cervical Region M59.02 - Segmental And Somato Dysfunction Of Cervical Region M59.03 - Segmental And Somato Dysfunction Of Cervical Region M54.12 - R/O Cervical  
M54.16 - Lumbar Radiculitis M54.2 Cervicalgia M51.26 Lumbar Disc Displacement S40.219a Shoulder Injury M62.40  
Muscle, Multiple Sites S33.40XA - Cervical Sprain/Strain S33.40XA - Lumbar Sprain/Strain M62.430 Muscle Spasm Of  
Contracture Of Muscle, Multiple Sites M50.28 Cervical Disc Displacement M51.26 Lumbar Disc Displacement S33.203.1  
Of Unspecified Type, Initial Encounter S33.403a Ankle Sprain M54.5 - Low Back Pain

☒ T150 Back Support  
☒ Lumbar Sacral Orthosis  
☒ Lumbar Back Cushion  
☒ Cervical Collar, Semi-rigid  
☒ Cervical Traction w/pump MRI  
☒ Egg Crate Mattress  
☒ B22 Bed  
☒ Heated Pad  
☒ Cold/Hot M-22 Circulation Unit  
☒ 10" x 14" Unit 4 Lead  
☒ Massage  
☒ Orthopedic Car Seat  
☒ Inflated Heat Lamp  
☒ Hot/Pool  
☒ Gait  
☒ Knee Support (R, L)  
☒ Knee Orthosis Fitted (R, L) MRI  
☒ Ankle Support (R, L)  
☒ Ankle Foot Orthosis (R, L) MRI

☐ Shoulder Support  
☐ Shoulder Elbow Wrist Orthosis (R, L) MRI  
☐ Wrist Support (R, L)  
☐ Lumbar Sacral Orthosis MRI  
☐ Elbow Support (R, L)  
☐ Elbow Orthosis (R, L) MRI  
☐ Wheel Chair  
☐ Cervical Pillow  
☐ T150 Orthosis MRI

3027 AV  
BROOKLYN, N.Y. 11224  
 Phone: 718.701.3478  
 Fax: 718.701.3479

*Notes:* Patient is to wear prescribed Durable Medical Equipment used of 4-6 weeks recalculation at that time.  
 All notes (if necessary)

*Letter of Medical Necessity*  
 I, the undersigned, certify that the above prescribed order for the above described Medical Equipment is necessary based on my diagnosis and as part of my overall treatment plan for my patient, who is the name at the top of this form. I have advised my patient that he/she has a right to choose medical equipment (DME) supplier that provides the prescribed products pursuant to this order. I am prescribing the items listed above.

[Signature]  
 NP/E 7013478.0602

40. The above prescription order form in paragraph 39 is a representative example and is fraudulent in nature as I never prescribed the items to be dispensed nor did I sign or authorize the prescription.

41. The above-mentioned prescription in paragraph 39 presented by Rosar Medical Equipment Corp. that is/are alleged to have been prescribed by me is/are fraudulent in nature as I never prescribed or authorized the item to be dispensed.

Myehm RX Inc.

42. I did not prescribe nor authorize the prescription for any medication, creams, patches, or ointments as allegedly provided by Myehm RX Inc. as indicated below. The following prescription is also fraudulent in nature as I did not sign the prescription; I did not prescribe or request that the following medication be given to the patient:

PLEASE COMPLETE AND SENT TO PHARMACY	
<p><b>PATIENT INFORMATION</b></p> <p>NAME: [REDACTED] D.O.B.: _____</p> <p>ADDRESS: [REDACTED] CITY: _____ STATE: _____ ZIP: _____</p> <p>PHONE: [REDACTED] ALLERGIES: _____</p> <p>DIAGNOSIS &amp; AFFECTED AREAS: _____</p>	
<p><b>MEDICATION ORDER</b></p> <div> <p><b>Diclofenac Sodium 3% Gel</b></p> <p>Sig: Apply to Affected areas twice a Day</p> <p>QTY: 100 _____ QTY: 200 _____ QTY: 300 _____</p> <p>Refills: _____ Grams _____</p> </div> <div> <p><b>Lidocaine Ointment 5%</b></p> <p>Sig: Apply to Affected areas twice a Day</p> <p>QTY: 100 _____ QTY: 200 _____</p> <p>Refills: _____ Grams _____</p> </div> <div> <p><b>Lidoderm Patch 5%</b></p> <p>Sig: Apply up to 3 patches to Affected Areas 12 Hours on 12 Hours off</p> <p>QTY: 30 _____ QTY: 60 _____</p> <p>Refills: _____</p> </div> <div> <p><b>Naproxen 550mg / Naproxen 500mg</b></p> <p>Sig: Take 1-2 tablets by mouth for pain as needed</p> <p>QTY: 80 _____ QTY: 160 _____ QTY: 240 _____</p> <p>Refills: _____</p> </div> <div> <p><b>Flexiril 10mg / Flexiril 5mg</b></p> <p>Sig: Take 1-2 tablets by mouth for pain as needed up to 3 times a day</p> <p>QTY: 80 _____ QTY: 160 _____</p> <p>Refills: _____</p> </div> <div> <p><b>Celebrax 100mg / Celebrax 200mg</b></p> <p>Sig: Take 1-2 tablets by mouth for pain as needed</p> <p>QTY: 30 _____ QTY: 60 _____</p> <p>Refills: _____</p> </div> <div> <p><b>Ibuprofen 600mg / Ibuprofen 800mg</b></p> <p>Sig: Take 1 tablets by mouth for pain as needed up to 4 times a day</p> <p>QTY: 80 _____ QTY: 160 _____</p> <p>Refills: _____</p> </div>	
<p><b>PRESCRIBER INFORMATION:</b></p> <p>NAME: <u>Arkam Raham</u></p> <p>ADDRESS: <u>632 Ultra Avenue</u></p> <p><u>Brooklyn, NY 11203</u></p> <p>PHONE: <u>(347) 955-4933</u> <u>(347) 955-4933</u></p> <p>DOB: _____ LIC# _____</p> <p>Prescriber Signature: <u>Arkam Raham</u></p> <p>Date: <u>3/13/00</u></p>	

43. The above prescription in paragraph 42 is a representative example and is fraudulent in nature as I never prescribed the items to be dispensed nor did I sign or authorize the prescription.

44. The prescription in paragraph 42 presented by Myehm RX Inc. that is/are alleged



to have been prescribed by me is/are fraudulent in nature as I never prescribed or authorized the item to be dispensed.

**Mednavet, Inc.**

45. I did not prescribe nor authorize the prescription for any durable medical equipment as allegedly provided by Mednavet, Inc. as indicated below. The following prescription is also fraudulent in nature as I did not sign the prescription, I did not prescribe or request that the following medication be given to the patient:

*DME Order Form*

Patient Name: [REDACTED] DOA: 8/16/12 DOB: 8/16/12

<input checked="" type="checkbox"/> Orthopedic Lumbar Cushion	<input checked="" type="checkbox"/> Electrodes (4 Leads)
<input type="checkbox"/> Thermal Heating Pads	<input checked="" type="checkbox"/> Massage (w/Infrared Lamp)
<input type="checkbox"/> Abdominal Support	<input checked="" type="checkbox"/> Water Therapy System w/Pump
<input checked="" type="checkbox"/> Dry Pressure Mattress	<input type="checkbox"/> Back Support TLSO
<input checked="" type="checkbox"/> Bed Boards	<input type="checkbox"/> Infrared Lamp
<input checked="" type="checkbox"/> Orthopedic Positioning Seat	<input type="checkbox"/> Cervical Collar
<input type="checkbox"/> Cervical Cover (2 place)	<input type="checkbox"/> Orthopedic Cervical Pillow
<input type="checkbox"/> Cane Adjustable	<input type="checkbox"/> Walker
<input type="checkbox"/> Walker (w/Wheels)	<input type="checkbox"/> Back Support TLSO
<input type="checkbox"/> Crutches Adjustable	<input type="checkbox"/> Cervical Posture Pump
<input checked="" type="checkbox"/> Shoulder Support	<input type="checkbox"/> Knee Brace KO Adjustable Hinge
<input type="checkbox"/> Wrist Support	<input checked="" type="checkbox"/> Lumbar Support LSO
<input type="checkbox"/> Elbow Support	OTHER: _____
<input type="checkbox"/> Ankle Support	
<input type="checkbox"/> Knee Support	

Physician's Signature: [Signature] NPI #: 1013920602

Physician's Name: Dr Arkam Rehman

Physician's Address: 632 Utica Ave Brooklyn NY 11203

Today's Date: \_\_\_\_\_

46. The above prescription order form in paragraph 45 is a representative example and is fraudulent in nature as I never prescribed the items to be dispensed nor did I sign or authorize the prescription.

47. The prescription in paragraph 45 presented by Mednavet, Inc. that is/are alleged

to have been prescribed by me is/are fraudulent in nature as I never prescribed or authorized the item to be dispensed.

**Medical Diagnostic Center**

48. I did not prescribe nor authorize a prescription for any diagnostic imaging studies, X-Rays, or Magnetic Resonance Imaging (MRIs) as allegedly provided by Medical Diagnostic Center as indicated below:



**MEDICAL DIAGNOSTIC CENTER**  
1664 East 14<sup>th</sup> Street Lower Level  
Brooklyn, NY 11229  
718 336 1865

**Patient Name:** [REDACTED]  
**Date of Birth:** [REDACTED]  
**Gender:** M  
**Date of Service:** 17-Dec-2020 12:19:58 PM  
**MRN:** SR427  
**Ref Physician:** DR.REHMAN  
**MRI OF THE RIGHT SHOULDER WITHOUT CONTRAST**  
**CLINICAL HISTORY:** MVA.

49. The MRI report referenced above report in paragraph 48 is a representative example and is fraudulent in nature as I never requested, prescribed, or ordered any diagnostic imaging studies, X-Rays, or Magnetic Resonance Imaging (MRIs).

50. To the best of my recollection the above-mentioned requests or prescription in paragraph 48 presented by Medical Diagnostic Center claiming that I ordered any diagnostic imaging studies, X-Rays, or Magnetic Resonance Imaging (MRIs) alleged to have been requested, prescribed, or ordered by me is/are fraudulent in nature as I never requested, prescribed, or ordered or authorized the test.

Levnic Inc.

51. I did not prescribe nor authorize the prescription for any durable medical equipment as allegedly provided by Levnic Inc. as indicated below. The following prescription is also fraudulent in nature as I did not sign the prescription, I did not prescribe or request that the following medication be given to the patient:

Rx/Prescription  
DME Order Form

Patient Name: [REDACTED] DOA: 1/24/00 DOB: \_\_\_\_\_

<input checked="" type="checkbox"/> Orthopedic Lumbar Cushion	<input type="checkbox"/> Electrodes (4 Leads) x
<input type="checkbox"/> Thermal Heating Pads	<input checked="" type="checkbox"/> Massager (w/Infrared Lamp)
<input type="checkbox"/> Abdominal Support	<input checked="" type="checkbox"/> Water Therapy System w/Pump
<input checked="" type="checkbox"/> Dry Pressure Mattress	<input type="checkbox"/> Back Support TLSO
<input checked="" type="checkbox"/> Bed Boards	<input type="checkbox"/> Infrared Lamp
<input checked="" type="checkbox"/> Orthopedic Positioning Seat	<input type="checkbox"/> Cervical Collar
<input checked="" type="checkbox"/> Cervical Cover (2 piece)	<input type="checkbox"/> Orthopedic Cervical Pillow
<input type="checkbox"/> Cane Adjustable	<input type="checkbox"/> Walker
<input type="checkbox"/> Walker (w/Wheels)	<input checked="" type="checkbox"/> Back Support TLSO
<input type="checkbox"/> Crutches Adjustable	<input type="checkbox"/> Cervical Posture Pump
<input checked="" type="checkbox"/> Shoulder Support	<input type="checkbox"/> Knee Brace KO Adjustable Hinge
<input type="checkbox"/> Wrist Support	<input type="checkbox"/> Lumbar Support LSO
<input type="checkbox"/> Elbow Support	OTHER: _____
<input type="checkbox"/> Ankle Support	
<input checked="" type="checkbox"/> Knee Support	

Physician's Signature: [Signature] NPI #: 1013920502

Physician's Name: Dr. Adnan Rehman

Physician's Address: 632 Utica Ave Brooklyn NY 11203

Today's Date: \_\_\_\_\_

52. The above prescription order form in paragraph 51 is a representative example and is fraudulent in nature as I never prescribed the items to be dispensed nor did I sign or authorize the prescription.

53. The above-mentioned prescription in paragraph 51 presented by Levnic Inc. that is/are alleged to have been prescribed by me is/are fraudulent in nature as I never prescribed or authorized the item to be dispensed.

Healing Services Inc.

54. I did not prescribe nor authorize the prescription for any durable medical equipment as allegedly provided by Healing Services Inc. as indicated below. The following prescription is also fraudulent in nature as I did not sign the prescription, I did not prescribe or request that the following equipment be given to the patient:

**R** Referral / Physician's Prescription

Please complete the information below and email/fax this form along with notes related to the relevant medical history & treatment to: [infosarmrecover@gmail.com](mailto:infosarmrecover@gmail.com) or Fax: 877-665-5589.

<b>PATIENT INFORMATION:</b>			
Patient Name:	[REDACTED]		Date of Birth: <u>SSA</u>
Patient Address:			
City:	State:	Zip Code:	Phone:

<b>DIAGNOSIS and RELATED INFO:</b>		Date of Incident: <u>03/11/2020</u>
Diagnosis:	ICD 10 Code:	
Symptoms:		
Limitations:		
Pain Level:	<input type="checkbox"/> No Pain <input type="checkbox"/> Mild Pain <input checked="" type="checkbox"/> Moderate Pain <input checked="" type="checkbox"/> Severe Pain <input type="checkbox"/> Worst Pain Possible	

**PRODUCT:** sam® (Sustained Acoustic Medicine) Unit and Coupling Patches

I am prescribing sam® which is an FDA cleared wearable Ultrasound for multi-hour treatment to reduce pain and accelerate the natural healing cascade for musculoskeletal related injuries. sam® has been clinically shown to increase Collagen Laydown, increase Oxygenated Hemoglobin in the muscle and increase Blood-flow to accelerate the recovery and reduction of pain for the associated injury. sam® can be used as an adjunct therapy with Physical Therapy and exercise. I certify that the sam® unit is medically indicated and in my opinion is reasonable and necessary to treat this patient's condition.

<input checked="" type="checkbox"/> C/SPINE	<input checked="" type="checkbox"/> T/SPINE	<input checked="" type="checkbox"/> L/BACK	<input type="checkbox"/> KNEE L/R	<input type="checkbox"/> ANKLE L/R	<input type="checkbox"/> SHOULDER L/R
<input type="checkbox"/> HAND L/R	<input type="checkbox"/> WRIST L/R	<input type="checkbox"/> ELBOW L/R	<input type="checkbox"/> HIP L/R	<input type="checkbox"/> OTHER _____	

**Duration of Treatment:**  
 1 Treatment per day; up to 4 Hrs. per day for up to ☐ 4 Weeks    ☐ 6 Weeks    ☒ 8 Weeks    ☐ Other \_\_\_\_\_

<b>PHYSICIAN'S INFORMATION:</b>			
Physician Print Name: <u>Arkham Rahman</u>			
Physician Address: <u>638 Utica Ave</u>			
City: <u>BHLYN</u>	State: <u>NY</u>	Zip Code: <u>11203</u>	Phone: <u>347-955-4929</u>
NPI #: <u>1013920692</u>		License #: _____	
Physician's Signature: <u>Arkham Rahman</u>			Date: <u>3/11/20</u>

NOTE: Please include (FAX or Email) all the appropriate Medical Notes with the Prescription

55. The above prescription order form in paragraph 54 is a representative example and is fraudulent in nature as I never prescribed the items to be dispensed nor did I sign or authorize the prescription.

56. The above-mentioned prescription in paragraph 54 presented by Healing Services Inc. that is/are alleged to have been prescribed by me is/are fraudulent in nature as I never prescribed or authorized the item to be dispensed.

### Ideal Care Pharmacy

57. I did not prescribe nor authorize the prescription for any medication, creams, patches, or ointments as allegedly provided by Ideal Care Pharmacy as indicated below. The following prescription is also fraudulent in nature as I did not sign the prescription, I did not prescribe or request that the following medication be given to the patient, nor did I agree with the Statement of Medical Necessity contained within the prescription:





THIS PRESCRIPTION IS INTENDED TO BE DELIVERED TO THE NAMED ADDRESSEE AND MAY CONTAIN INFORMATION THAT IS CONFIDENTIAL, PRIVILEGED AND PROPRIETARY OR SUBJECT FROM DISCLOSURE UNDER APPLICABLE LAW. IF IT RECEIVED BY ANYONE OTHER THAN THE NAMED ADDRESSEE, PLEASE DESTROY.		
FIRST NAME: [REDACTED]	DOB: [REDACTED]	DOA: [REDACTED]
ADDRESS: [REDACTED]	CITY: [REDACTED]	STATE: [REDACTED] ZIP: [REDACTED]
PHONE: [REDACTED]	[REDACTED]	[REDACTED]
ALLERGIES: [REDACTED]		
ICD-9/BODYPART: [REDACTED]		
<p><u>LIDOCAINE 5% OINTMENT</u></p> <p>SIG: APPLY TO AFFECTED AREA TWICE A DAY</p> <p>DISP: 200GM 250GM</p> <p>REFILLS: [REDACTED]</p>	<p><u>CELEBREX 200MG ORAL CAPSULE</u></p> <p>DISP: 30 60</p> <p>SIG: [REDACTED]</p> <p>REFILLS: [REDACTED]</p>	<p><u>NAPROXEN 550MG TABLET</u></p> <p>DISP: 30 60</p> <p>SIG: [REDACTED]</p> <p>REFILLS: [REDACTED]</p>
<p><u>DICLOFENAC SODIUM 3% GEL</u></p> <p>SIG: APPLY TO AFFECTED AREA TWICE A DAY</p> <p>DISP: 75GM 75GM</p> <p>REFILLS: [REDACTED]</p>	<p><u>MELoxicAM 15MG TABLET</u></p> <p>DISP: 30 60</p> <p>SIG: [REDACTED]</p> <p>REFILLS: [REDACTED]</p>	<p><u>BAGLOFEN 20MG TABLET</u></p> <p>DISP: 30 60 90</p> <p>SIG: [REDACTED]</p> <p>REFILLS: [REDACTED]</p>
<p>OTHER:</p> <p>DISP: 30 60</p> <p>SIG: [REDACTED]</p> <p>REFILLS: [REDACTED]</p>		
<p><b>PRESCRIBER INFORMATION:</b></p> <p>NAME: Dr. ARKAM BENJMAN</p> <p>ADDRESS: 3027 AVENUE V, BROOKLYN, NY 11229</p> <p>PHONE: (347) 702-9725</p> <p>NPI# 1013920602 LIC# 298627</p>		
<p><b>STATEMENT OF MEDICAL NECESSITY:</b></p> <p style="font-size: x-small;">SIDE EFFECTS ASSOCIATED WITH ORAL ADMINISTRATION CAN OFTEN BE AVOIDED WHEN MEDICATIONS ARE USED TOPICALLY. WHEN MEDICATIONS ARE ADMINISTERED TOPICALLY, THEY ARE NOT ABSORBED THROUGH GASTROINTESTINAL SYSTEM AND DO NOT UNDERGO FIRST PASS METABOLISM. TOPICAL CREAMS/PATCHES MAY BE USED IN CONJUNCTION WITH LOWER DOSES OF ORAL MEDICATIONS TO PREVENT SIDE EFFECTS OF ORAL MEDICATIONS.</p>		
<p>PHYSICIAN SIGNATURE: [REDACTED]</p>		

58. The above prescription order form in paragraph 57 is a representative example and is fraudulent in nature as I never prescribed the items to be dispensed nor did I sign or authorize



the prescription.

59. The following prescriptions are also fraudulent in nature as I did not sign the prescriptions nor did not prescribe or request that the following medications be given to the patient:

<p style="text-align: center;"><b>RECEIPT</b></p>  <p><b>Ideal Care Pharmacy Inc.</b>        811 Ave U      Pht: (718) 382-1990    (855)382-1990        Brooklyn NY 11223      Fax: (718) 382-1990 DEAR: F0316921  <b>Rx#:515298      Date Filled: 2/3/2021</b></p> <p>██████████        773 E 39TH ST        BROOKLYN NY 11210        (646)789-1200</p> <p><b>DICLOFENAC SODIUM GEL 3%</b>        NDC: 68462-0355-94</p> <p><b>Dr. REHMAN, A</b>        REFILLS: 0        Qty: 200        Plan: C</p> <p style="text-align: right;"><b>Due: \$2599.90</b></p> <p style="text-align: center;">THIS IS YOUR RECEIPT. PLEASE RETAIN        FOR YOUR TAX OR INSURANCE.</p> <p style="text-align: center;"><b>RECEIPT</b></p>  <p><b>Ideal Care Pharmacy Inc.</b>        811 Ave U      Pht: (718) 382-1990    (855)382-1990        Brooklyn NY 11223      Fax: (718) 382-1990 DEAR: F0316921  <b>Rx#:515298      Date Filled: 2/3/2021</b></p> <p>██████████        773 E 39TH ST        BROOKLYN NY 11210        (646)789-1200</p> <p><b>DICLOFENAC SODIUM GEL 3%</b>        NDC: 68462-0355-94</p> <p><b>Dr. REHMAN, A</b>        REFILLS: 0        Qty: 200        Plan: C</p> <p style="text-align: right;"><b>Due: \$2599.90</b></p> <p style="text-align: center;">THIS IS YOUR RECEIPT. PLEASE RETAIN        FOR YOUR TAX OR INSURANCE.</p>	<p style="text-align: center;"><b>RECEIPT</b></p>  <p><b>Ideal Care Pharmacy Inc.</b>        811 Ave U      Pht: (718) 382-1990    (855)382-1990        Brooklyn NY 11223      Fax: (718) 382-1990 DEAR: F0316921  <b>Rx#:515299      Date Filled: 2/3/2021</b></p> <p>██████████        773 E 39TH ST        BROOKLYN NY 11210        (646)789-1200</p> <p><b>NAPROXEN SODIUM TAB 550MG</b>        NDC: 68462-0178-01</p> <p><b>Dr. REHMAN, A</b>        REFILLS: 0        Qty: 60        Plan: C</p> <p style="text-align: right;"><b>Due: \$240.29</b></p> <p style="text-align: center;">THIS IS YOUR RECEIPT. PLEASE RETAIN        FOR YOUR TAX OR INSURANCE.</p> <p style="text-align: center;"><b>RECEIPT</b></p>  <p><b>Ideal Care Pharmacy Inc.</b>        811 Ave U      Pht: (718) 382-1990    (855)382-1990        Brooklyn NY 11223      Fax: (718) 382-1990 DEAR: F0316921  <b>Rx#:515299      Date Filled: 2/3/2021</b></p> <p>██████████        773 E 39TH ST        BROOKLYN NY 11210        (646)789-1200</p> <p><b>NAPROXEN SODIUM TAB 550MG</b>        NDC: 68462-0179-01</p> <p><b>Dr. REHMAN, A</b>        REFILLS: 0        Qty: 60        Plan: C</p> <p style="text-align: right;"><b>Due: \$240.29</b></p> <p style="text-align: center;">THIS IS YOUR RECEIPT. PLEASE RETAIN        FOR YOUR TAX OR INSURANCE.</p>
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60. The above prescription receipts in paragraph 59 are a representative example and are fraudulent in nature as I never prescribed the items to be dispensed nor did I sign or authorize the prescription.


61. The above-mentioned prescription in paragraph 59 presented by Ideal Care Pharmacy Inc. that is/are alleged to have been prescribed by me is/are fraudulent in nature as I



never prescribed or authorized the item to be dispensed.


### Essential RX

62. I did not prescribe nor authorize the prescription for any medication, creams, patches, or ointments as allegedly provided by Essential RX as indicated below. The following prescriptions are also fraudulent in nature as I did not sign the prescriptions, I did not prescribe the medications nor request that the following medications be given to the patient:

<b>Essential Rx</b> 115-07 Jamaica Ave Phone: (718)441-7414 Fax: (718)441-7415		<b>Richmond Hill, NY 11418</b> 12/8/2020 12:08:52PM	
Rx Pres: ARKAM REHMAN 3027 AVE V BROOKLYN, NY 11229 Phone: (347)702-9725 Fax:	Ord Date: 12/08/2020 NPI#: 1013920602 LIC#: 298627 DEAS: SPE:		
Patient: [REDACTED] DOB: [REDACTED] Gender: M Rdx#: 72363 Address: 773 EAST 39TH STREET Phone: (646)789-1200 Qty Ord: 250.000 Qty: 250.00 Days: 30 Refills: 0 PH/TH:DM Class: 0	<b>Drug: LIDOCAINE 5% OINT</b>  Sign: <u>[Signature]</u> Date: <u>12/10/20</u> This Prescription Will be Filled Generically Unless Prescriber Writes "DAW" in the Box <input type="checkbox"/> N		

Telephone Rx

Rx#: 72363 DOB: 02/19/70 RMD: 12/08/2020 FIRM: (001)  
COURTNEY LARK 115 EAST 39TH STREET BROOKLYN NY 11218  
250 LIDOCAINE OINT 5% 32255-0008-55 TILIGENT,  
Dr. REHMAN, ARKAM DEAN PH: (347)702-9725 Refills: 0  
Copy: 10.00 In: 7.14: \$1.00 Auth:

<b>Essential Rx</b> 115-07 Jamaica Ave Phone: (718)441-7414 Fax: (718)441-7415		<b>Richmond Hill, NY 11418</b> 12/8/2020 12:08:52PM	
Rx Pres: ARKAM REHMAN 3027 AVE V BROOKLYN, NY 11229 Phone: (347)702-9725 Fax:	Ord Date: 12/08/2020 NPI#: 1013920602 LIC#: 298627 DEAS: SPE:		
Patient: [REDACTED] DOB: [REDACTED] Gender: M Rdx#: 72364 Address: 773 EAST 39TH STREET Phone: (646)789-1200 Qty Ord: 60.000 Qty: 60.00 Days: 30 Refills: 0 PH/TH:DM Class: 0	<b>Drug: CELECOXIB 200MG CAP</b>  Sign: <u>[Signature]</u> Date: <u>12/10/20</u> This Prescription Will be Filled Generically Unless Prescriber Writes "DAW" in the Box <input type="checkbox"/> N		

Telephone Rx

Rx#: 72364 DOB: 02/19/70 RMD: 12/08/2020 FIRM: (001)  
COURTNEY LARK 115 EAST 39TH STREET BROOKLYN NY 11218  
60 CELECOXIB CAP 200MG 42771-0144-01 MICRO LABS  
Dr. REHMAN, ARKAM DEAN PH: (347)702-9725 Refills: 0  
Copy: 20.10 In: 7.14: \$1.00 Auth:

63. The above prescription in paragraph 62 are a representative example and are fraudulent in nature as I never prescribed the items to be dispensed nor did I sign or authorize the prescriptions.

64. To the best of my recollection the above-mentioned prescriptions in paragraph 62 presented by Essential RX that is/are alleged to have been prescribed by me is/are fraudulent in nature as I never prescribed or authorized the item to be dispensed.

### Flushing Medical Supply, Inc.

65. I did not prescribe nor authorize the prescription for any durable medical equipment as allegedly provided by Flushing Medical Supply, Inc. as indicated below. The following prescription is also fraudulent in nature as I did not sign the prescription, I did not prescribe or request that the following equipment be given to the patient:

## Rx Referral / Physician's Prescription

Please complete the information below and attach this form along with notes related to the relevant medical history & treatment(s).

<b>PATIENT</b>	
Patient Name: <span style="background-color: black; color: black;">[REDACTED]</span>	Date of Birth: _____ SSN: _____
Patient Address: _____	
City: _____ State: _____ Zip Code: _____ Phone: _____	
<b>DIAGNOSIS and RELATED INFO:</b>	
Diagnosis: _____	Date of Incident: _____
Symptoms: _____	ICD 10 Code: _____
Limitation: _____	
Pain Level: <input type="checkbox"/> No Pain <input type="checkbox"/> Mild Pain <input type="checkbox"/> Moderate Pain <input type="checkbox"/> Severe Pain <input type="checkbox"/> Very Severe Pain	
<b>PRODUCT:</b> <i>soni</i> ® (Sustained Acoustic Medicine) Unit and Coupling Patches <i>soni</i> ® is an FDA cleared wearable Ultrasound for multi-hour treatment of chronic pain. It provides a natural healing cascade for musculoskeletal related issues. <i>soni</i> ® has been clinically shown to increase blood flow, lay down, increase oxygenated hemoglobin in the muscle and increase blood flow to the recovery and reduction of pain. The <i>soni</i> ® can be used again day, not the same day. <i>soni</i> ® is medically indicated and in my opinion is safe and necessary to treat the patient's condition.	
<input checked="" type="checkbox"/> LUMBAR <input type="checkbox"/> THORACIC <input type="checkbox"/> NECK <input type="checkbox"/> KNEE L/R <input type="checkbox"/> ANKLE L/R <input type="checkbox"/> SHOULDER L/R <input type="checkbox"/> HAND L/R <input type="checkbox"/> WRIST L/R <input type="checkbox"/> ELBOW L/R <input type="checkbox"/> HIP L/R <input type="checkbox"/> OTHER: _____	
<b>Duration of Treatment:</b> <input type="checkbox"/> 1 treatment per day; up to 4 hrs. per day for up to <input type="checkbox"/> 4 Weeks <input checked="" type="checkbox"/> 6 Weeks <input type="checkbox"/> 8 Weeks <input type="checkbox"/> Other: _____	
<b>PHYSICIAN INFORMATION:</b> Physician Print Name: <u>Alexander Lekman</u> Physician Address: <u>3027 Ave V</u> City: <u>Brooklyn</u> State: <u>NY</u> Zip Code: <u>11229</u> NPI: <u>1013920602</u> License: <u>298627</u> Physician Signature: <u>[Signature]</u> Date: <u>7/20/20</u>	

NOTE: Please include FAX or Email all the appropriate Medical Notes with the Prescription.

66. The above prescription order form in paragraph 65 is a representative example and is fraudulent in nature as I never prescribed the items to be dispensed nor did I sign or authorize the prescription.

67. The above-mentioned prescription in paragraph 65 presented by Flushing Medical Supply, Inc. that is/are alleged to have been prescribed by me is/are fraudulent in nature as I never prescribed or authorized the item to be dispensed.

### Eclipse Medical Imaging, P.C.

68. I did not prescribe nor authorize the prescription for any diagnostic imaging studies, X-Rays, or Magnetic Resonance Imaging (MRIs) as allegedly provided by Eclipse Medical Imaging, P.C. as indicated below:


**MEDICAL  
IMAGING P.C.**

651 Coney Island Avenue, Brooklyn, NY 11218 • Tel: (718) 284-0700 • Fax: (718) 284-0800

 ARKAM REHMAN, M.D.  
 632 UTICA AVENUE  
 BROOKLYN, NY 11203

 DOS: 02/17/2020  
 DOB: 07/08/1960  
 FILE #: 35751  
 DOI: 01/24/2020

PATIENT: [REDACTED]

EXAM: MRI OF THE LEFT SHOULDER W/O CONTRAST

Dear Dr. Rehman,


**MEDICAL  
IMAGING P.C.**

651 Coney Island Avenue, Brooklyn, NY 11218 • Tel: (718) 284-0700 • Fax: (718) 284-0800

*Transmit 2/10/20 after 4.*

Patient: <u>Cheryl Roberts</u>		Phone: _____
Today's Date: <u>2-11-2020</u>	Appointment Date: <u>2/10</u>	Time: <u>5pm</u>
Referring Physician: <u>Arkam Rehman</u>	Phone: _____	Fax: _____
Referring Physician's Address: <u>632 Utica</u>	Signature: <u>Arkam Rehman</u>	
Clinical History:		
<input type="checkbox"/> Call-in Requested <input type="checkbox"/> CD <input type="checkbox"/> Other		<input type="checkbox"/> Please, Send More Referral Peds PLEASE OBTAIN NECESSARY AUTHORIZATION TO AVOID DELAYS
DIAGNOSIS HISTORY:		Authorization # _____
<u>MVA.</u>		

MRI INFORMATION: MRI is contraindicated in patients with pacemakers, ear implants, cerebral aneurysm clips, metal in eyes, etc.

69. The MRI report and prescription referenced above in paragraph 68 are a representative example and are fraudulent in nature as I never requested, prescribed, or ordered any diagnostic imaging studies, X-Rays, or Magnetic Resonance Imaging (MRIs).

70. The above-mentioned requests or prescription in paragraph 68 presented by Eclipse Medical Imaging, P.C. claiming that I ordered any diagnostic imaging studies, X-Rays, or Magnetic Resonance Imaging (MRIs) alleged to have been requested, prescribed, or ordered by me is/are fraudulent in nature as I never requested, prescribed, or ordered or authorized the test.

**Boulevard 9229 LLC**

71. I did not prescribe nor authorize the prescription for any medication, creams, patches, or ointments as allegedly provided by Boulevard 9229 LLC as indicated below. The following prescription is also fraudulent in nature as I did not sign the prescription, I did not

prescribe or request that the following medication be given to the patient, nor did I agree with the Statement of Medical Necessity contained within the prescription:

PRESCRIPTION ORDER FORM		THIS FACSIMILE TRANSMISSION IS INTENDED TO BE DELIVERED TO THE NAMED ADDRESSEE AND MAY CONTAIN INFORMATION THAT IS CONFIDENTIAL, PROPRIETARY OR OTHERWISE PROTECTED BY APPLICABLE LAW. IF IT IS RECEIVED BY ANYONE OTHER THAN THE NAMED ADDRESSEE, PLEASE CONTACT US AND DESTROY. © 2019																
NAME: [REDACTED] DOB: [REDACTED] DOA: [REDACTED]																		
ADDRESS: [REDACTED] CITY: [REDACTED] STATE: [REDACTED] ZIP: [REDACTED]																		
HOME PHONE: [REDACTED] CELL: [REDACTED]																		
EMAIL: [REDACTED]																		
INSURANCE: [REDACTED]																		
CLAIM/CARRIER: [REDACTED] POLICY/NO: [REDACTED]																		
<table border="1"> <tr> <td> <b>ICD10/BODY PARTS:</b>  <b>DICLOFENAC SODIUM GEL 1%</b>            SIG: APPLY TO AFFECTED AREAS TWICE A DAY            DISP: 100 200 300 GRAMS            REFILLS:         </td> <td> <b>LIDOCaine Ointment 5%</b>            SIG: APPLY TO AFFECTED AREAS TWICE A DAY            DISP: 150 200 250 GRAMS            REFILLS:         </td> <td> <b>LIDOCaine 5% PATCH</b>            SIG: APPLY UP TO 8 PATCHES TO AFFECTED AREA 12 HOURS ON 12 HOURS OFF            DISP: 30 60 90            REFILLS:         </td> </tr> <tr> <td> <b>DICLOFENAC 1% GEL</b>            SIG: APPLY 2-4 GRAMS TO AFFECTED AREA FOUR TIMES A DAY            DISP: 300            REFILLS:         </td> <td> <b>MILPROFEN TABLETS</b>            SIG: [REDACTED]            DISP: 30 60 90 120            REFILLS:         </td> <td> <b>MILPROFEN 500MG TABLETS</b>            SIG: [REDACTED]            DISP: 30 60            REFILLS:         </td> </tr> <tr> <td> <b>DIPHENHYDRAmine CAPSULES</b>            SIG: [REDACTED]            STRENGTH: 25 50 100 150            DISP: 30 60            REFILLS:         </td> <td> <b>CYCLOSPORINE 100MG TABLETS</b>            SIG: [REDACTED]            DISP: 30 60 90            REFILLS:         </td> <td> <b>CYCLOSPORINE 250MG TABLETS</b>            SIG: [REDACTED]            DISP: 60 90 120            REFILLS:         </td> </tr> <tr> <td> <b>SUMATRIPTAN 50MG TABS</b>            SIG: TAKE 1 TABLET BY MOUTH ONCE AT ONSET OF HEADACHE, MAY REPEAT ONE TABLET ONCE AFTER 2 HOURS            DISP: 3 15            REFILLS:         </td> <td> <b>DIHYDROERGOTANINE NASAL SPRAY 4MG/0.1ML (ONLY FOR HEADACHES)</b>            SIG: INSTILL 1 ACTUATION IN EACH NOSTRIL EVERY 15 MINUTES AT ONSET OF HEADACHE, MAY REPEAT ONCE            DISP: 8 ML            REFILLS:         </td> <td> <b>ZIPSON 250MG CAPSULES (ORAL)</b>            SIG: TAKE 1 TABLET BY MOUTH FOUR TIMES PER DAY AS DIRECTED            DISP: 120 CAPSULES            REFILLS:         </td> </tr> <tr> <td> <b>ALBUTEROL 200MG CAPSULES</b>            SIG: [REDACTED]            DISP: 30 60 90            REFILLS:         </td> <td> <b>1% ANESTHETIC PATCH WITH LIDOCaine 4%</b>            SIG: APPLY 1 PATCH TO AFFECTED AREA ONCE A DAY            SIG: APPLY 1 PATCH TO AFFECTED AREA TWICE A DAY            DISP: 30 60            REFILLS:         </td> <td> <b>OTHER</b>            SIG: [REDACTED]            DISP: 30 60 90            REFILLS:         </td> </tr> </table>				<b>ICD10/BODY PARTS:</b> <b>DICLOFENAC SODIUM GEL 1%</b> SIG: APPLY TO AFFECTED AREAS TWICE A DAY DISP: 100 200 300 GRAMS REFILLS:	<b>LIDOCaine Ointment 5%</b> SIG: APPLY TO AFFECTED AREAS TWICE A DAY DISP: 150 200 250 GRAMS REFILLS:	<b>LIDOCaine 5% PATCH</b> SIG: APPLY UP TO 8 PATCHES TO AFFECTED AREA 12 HOURS ON 12 HOURS OFF DISP: 30 60 90 REFILLS:	<b>DICLOFENAC 1% GEL</b> SIG: APPLY 2-4 GRAMS TO AFFECTED AREA FOUR TIMES A DAY DISP: 300 REFILLS:	<b>MILPROFEN TABLETS</b> SIG: [REDACTED] DISP: 30 60 90 120 REFILLS:	<b>MILPROFEN 500MG TABLETS</b> SIG: [REDACTED] DISP: 30 60 REFILLS:	<b>DIPHENHYDRAmine CAPSULES</b> SIG: [REDACTED] STRENGTH: 25 50 100 150 DISP: 30 60 REFILLS:	<b>CYCLOSPORINE 100MG TABLETS</b> SIG: [REDACTED] DISP: 30 60 90 REFILLS:	<b>CYCLOSPORINE 250MG TABLETS</b> SIG: [REDACTED] DISP: 60 90 120 REFILLS:	<b>SUMATRIPTAN 50MG TABS</b> SIG: TAKE 1 TABLET BY MOUTH ONCE AT ONSET OF HEADACHE, MAY REPEAT ONE TABLET ONCE AFTER 2 HOURS DISP: 3 15 REFILLS:	<b>DIHYDROERGOTANINE NASAL SPRAY 4MG/0.1ML (ONLY FOR HEADACHES)</b> SIG: INSTILL 1 ACTUATION IN EACH NOSTRIL EVERY 15 MINUTES AT ONSET OF HEADACHE, MAY REPEAT ONCE DISP: 8 ML REFILLS:	<b>ZIPSON 250MG CAPSULES (ORAL)</b> SIG: TAKE 1 TABLET BY MOUTH FOUR TIMES PER DAY AS DIRECTED DISP: 120 CAPSULES REFILLS:	<b>ALBUTEROL 200MG CAPSULES</b> SIG: [REDACTED] DISP: 30 60 90 REFILLS:	<b>1% ANESTHETIC PATCH WITH LIDOCaine 4%</b> SIG: APPLY 1 PATCH TO AFFECTED AREA ONCE A DAY SIG: APPLY 1 PATCH TO AFFECTED AREA TWICE A DAY DISP: 30 60 REFILLS:	<b>OTHER</b> SIG: [REDACTED] DISP: 30 60 90 REFILLS:
<b>ICD10/BODY PARTS:</b> <b>DICLOFENAC SODIUM GEL 1%</b> SIG: APPLY TO AFFECTED AREAS TWICE A DAY DISP: 100 200 300 GRAMS REFILLS:	<b>LIDOCaine Ointment 5%</b> SIG: APPLY TO AFFECTED AREAS TWICE A DAY DISP: 150 200 250 GRAMS REFILLS:	<b>LIDOCaine 5% PATCH</b> SIG: APPLY UP TO 8 PATCHES TO AFFECTED AREA 12 HOURS ON 12 HOURS OFF DISP: 30 60 90 REFILLS:																
<b>DICLOFENAC 1% GEL</b> SIG: APPLY 2-4 GRAMS TO AFFECTED AREA FOUR TIMES A DAY DISP: 300 REFILLS:	<b>MILPROFEN TABLETS</b> SIG: [REDACTED] DISP: 30 60 90 120 REFILLS:	<b>MILPROFEN 500MG TABLETS</b> SIG: [REDACTED] DISP: 30 60 REFILLS:																
<b>DIPHENHYDRAmine CAPSULES</b> SIG: [REDACTED] STRENGTH: 25 50 100 150 DISP: 30 60 REFILLS:	<b>CYCLOSPORINE 100MG TABLETS</b> SIG: [REDACTED] DISP: 30 60 90 REFILLS:	<b>CYCLOSPORINE 250MG TABLETS</b> SIG: [REDACTED] DISP: 60 90 120 REFILLS:																
<b>SUMATRIPTAN 50MG TABS</b> SIG: TAKE 1 TABLET BY MOUTH ONCE AT ONSET OF HEADACHE, MAY REPEAT ONE TABLET ONCE AFTER 2 HOURS DISP: 3 15 REFILLS:	<b>DIHYDROERGOTANINE NASAL SPRAY 4MG/0.1ML (ONLY FOR HEADACHES)</b> SIG: INSTILL 1 ACTUATION IN EACH NOSTRIL EVERY 15 MINUTES AT ONSET OF HEADACHE, MAY REPEAT ONCE DISP: 8 ML REFILLS:	<b>ZIPSON 250MG CAPSULES (ORAL)</b> SIG: TAKE 1 TABLET BY MOUTH FOUR TIMES PER DAY AS DIRECTED DISP: 120 CAPSULES REFILLS:																
<b>ALBUTEROL 200MG CAPSULES</b> SIG: [REDACTED] DISP: 30 60 90 REFILLS:	<b>1% ANESTHETIC PATCH WITH LIDOCaine 4%</b> SIG: APPLY 1 PATCH TO AFFECTED AREA ONCE A DAY SIG: APPLY 1 PATCH TO AFFECTED AREA TWICE A DAY DISP: 30 60 REFILLS:	<b>OTHER</b> SIG: [REDACTED] DISP: 30 60 90 REFILLS:																
<b>PRESCRIBER INFORMATION</b> NAME: <u>Arham Rahman</u> ADDRESS: <u>3024 ave V</u> CITY: <u>BROOKLYN</u> STATE: <u>NY</u> ZIP: <u>11229</u> PHONE: <u>1013920602</u> UCR: <u>298624</u>																		
<b>STATEMENT OF MEDICAL NECESSITY</b> THE EFFECTS ASSOCIATED WITH ORAL ADMINISTRATION CAN OFTEN BE AVOIDED WHEN MEDICATIONS ARE USED TOPICALLY. WHEN MEDICATIONS ARE ADMINISTERED TOPICALLY, THEY ARE NOT ABSORBED THROUGH THE GASTROINTESTINAL SYSTEM AND DO NOT UNDERGO FIRST PASS HEPATIC METABOLISM. TOPICAL CREAMS/ PATCHES WILL BE USED BY CONJUNCTION WITH LOWER DOSES OF ORAL MEDICATIONS TO PREVENT DEPENDENCE AND SIDE EFFECTS OF ORAL MEDICATIONS. PHYSICIAN SIGNATURE: <u>[Signature]</u> DATE: <u>4/29/20</u>																		

72. The above prescription in paragraph 71 is a representative example and are fraudulent in nature as I never prescribed the items to be dispensed nor did I sign or authorize the prescriptions.

73. The above-mentioned prescription in paragraph 71 presented by Boulevard 9229 LLC that is/are alleged to have been prescribed by me is/are fraudulent in nature as I never prescribed or authorized the item to be dispensed.

### Bisoma Pharmacy Inc.

74. I have never prescribed nor authorized a prescription for any medication, creams, patches, or ointments as allegedly provided by Bisoma Pharmacy Inc. The following prescriptions are also fraudulent in nature as I did not sign the prescription, I did not prescribe or request that



the following medication be given to the patient:

**BISOMA PHARMACY INC.**  
20520 Jamaica Ave Hollis, NY 11423  
Phone: (718)217-2091 Fax: (718)217-2138 11/9/2020 1:16:02PM

Rx Pres: ARKAM REHMAN Ord Date: 10/19/2020  
3027 AVE V NPI# 1013920602  
BROOKLYN, NY 11229 LIC# 298627  
Phone: (347)702-9725 DEAN# BR4816685  
FAX# SPI#

Patient: [REDACTED] DOB: [REDACTED] Gender F RA#: 61077  
Address: 1410 ROCKAWAY PKWY BROOKLYN, NY 11236  
Phone: (646)573-4789 Qty Ord: 60.000  
Qty: 60.00 Days: 30 Refills: 0 PH/TH/YI Class 0

Drug: IBUPROFEN 600MG TAB

Sig: TAKE ONE TABLET BY MOUTH TWICE A DAY

Signature \_\_\_\_\_ Date \_\_\_\_\_  
This Prescription Will be Filled Generically Unless \_\_\_\_\_ N  
Prescriber Writes "DAW" in the Box Dispense As Written

**BISOMA PHARMACY INC.**  
20520 Jamaica Ave Hollis, NY 11423  
Phone: (718)217-2091 Fax: (718)217-2138 11/9/2020 1:16:02PM

Rx Pres: ARKAM REHMAN Ord Date: 10/19/2020  
3027 AVE V NPI# 1013920602  
BROOKLYN, NY 11229 LIC# 298627  
Phone: (347)702-9725 DEAN# BR4816685  
FAX# SPI#

Patient: [REDACTED] DOB: [REDACTED] Gender F RA#: 61079  
Address: 1410 ROCKAWAY PKWY BROOKLYN, NY 11236  
Phone: (646)573-4789 Qty Ord: 60.000  
Qty: 60.00 Days: 30 Refills: 0 PH/TH/YI Class 0

Drug: LIDOCAINE 5% FILM ER

Sig: APPLY UP TO 3 PATCHES TO AFFECTED AREAS 12 HOURS ON 12 HOURS OFF

Signature \_\_\_\_\_ Date \_\_\_\_\_  
This Prescription Will be Filled Generically Unless \_\_\_\_\_ N  
Prescriber Writes "DAW" in the Box Dispense As Written

**BISOMA PHARMACY INC.**  
20520 Jamaica Ave Hollis, NY 11423  
Phone: (718)217-2091 Fax: (718)217-2138 11/9/2020 1:16:02PM

Rx Pres: ARKAM REHMAN Ord Date: 10/19/2020  
3027 AVE V NPI# 1013920602  
BROOKLYN, NY 11229 LIC# 298627  
Phone: (347)702-9725 DEAN# BR4816685  
FAX# SPI#

Patient: [REDACTED] DOB: [REDACTED] Gender F RA#: 61078  
Address: 1410 ROCKAWAY PKWY BROOKLYN, NY 11236  
Phone: (646)573-4789 Qty Ord: 250.000  
Qty: 250.00 Days: 30 Refills: 0 PH/TH/YI Class 0

Drug: LIDOCAINE 5% OINT

Sig: APPLY TO AFFECTED AREAS TWICE A DAY

Signature \_\_\_\_\_ Date \_\_\_\_\_  
This Prescription Will be Filled Generically Unless \_\_\_\_\_ N  
Prescriber Writes "DAW" in the Box Dispense As Written

**BISOMA PHARMACY INC.**  
20520 Jamaica Ave Hollis, NY 11423  
Phone: (718)217-2091 Fax: (718)217-2138 11/9/2020 1:16:02PM

Rx Pres: ARKAM REHMAN Ord Date: 10/19/2020  
3027 AVE V NPI# 1013920602  
BROOKLYN, NY 11229 LIC# 298627  
Phone: (347)702-9725 DEAN# BR4816685  
FAX# SPI#

Patient: [REDACTED] DOB: [REDACTED] Gender F RA#: 61078  
Address: 1410 ROCKAWAY PKWY BROOKLYN, NY 11236  
Phone: (646)573-4789 Qty Ord: 30.000  
Qty: 30.00 Days: 30 Refills: 0 PH/TH/YI Class 0

Drug: CYCLOBENZAPRINE HYDROCHLORIDE 5MG TAB

Sig: TAKE ONE TABLET BY MOUTH DAILY AT BEDTIME

Signature \_\_\_\_\_ Date \_\_\_\_\_  
This Prescription Will be Filled Generically Unless \_\_\_\_\_ N  
Prescriber Writes "DAW" in the Box Dispense As Written

75. The above prescription in paragraph 74 are a representative example and are fraudulent in nature as I never prescribed the items to be dispensed nor did I sign or authorize the prescriptions.

76. To the best of my recollection the above prescriptions in paragraph 74 presented by Bisoma Pharmacy Inc. that is/are alleged to have been prescribed by me is/are fraudulent in nature as I never prescribed or authorized the item to be dispensed.

#### Briarwood RX Inc.

77. I have never prescribed nor authorized a prescription for any medication, creams, patches, or ointments as allegedly provided by Briarwood RX Inc. The following prescriptions are

also fraudulent in nature as I did not sign the prescription, I did not prescribe or request that the following medication be given to the patient:

<b>BRIARWOOD RX INC</b>		<b>BRIARWOOD, NY 11435</b>	
8515 MAIN ST			
Phone: (718)480-6740		Fax: (516)408-3992	
6/26/2020 11:16:01AM			
Rx Pres: ARKAM REHMAN		Ord Date: 06/17/2020	
3027 AVE V		NPI#: 1013920602	
BROOKLYN, NY 11229		LIC#: 298627	
Phone: (347)702-9725		DEA#: BR4816685	
Fax: [REDACTED]		SPE#: [REDACTED]	
Patient: [REDACTED]		[REDACTED]	
DOB: [REDACTED]	Gender: M	Rx#: 60434	
Address: 245 COZINE AVE APT 6F		BROOKLYN, NY 11207	
Phone: (347)744-2423		Qty Ord: 250.000	
Qty: 250.00	Days: 30	Refills: 0	PH/TH: RH Class: 0
Drug: LIDOCAINE 5% OINT			
Sig: APPLY TO AFFECTED AREAS TWICE A DAY			
Signature: [REDACTED]		Date: [REDACTED]	
This Prescription Will be Filled Generically Unless		N	
Prescriber Writes "DAW" in the Box		Dispense As Written	

<b>BRIARWOOD RX INC</b>		<b>BRIARWOOD, NY 11435</b>	
8515 MAIN ST			
Phone: (718)480-6740		Fax: (516)408-3992	
6/26/2020 11:16:01AM			
Rx Pres: ARKAM REHMAN		Ord Date: 06/17/2020	
3027 AVE V		NPI#: 1013920602	
BROOKLYN, NY 11229		LIC#: 298627	
Phone: (347)702-9725		DEA#: BR4816685	
Fax: [REDACTED]		SPE#: [REDACTED]	
Patient: [REDACTED]		[REDACTED]	
DOB: [REDACTED]	Gender: M	Rx#: 60436	
Address: 245 COZINE AVE APT 6F		BROOKLYN, NY 11207	
Phone: (347)744-2423		Qty Ord: 60.000	
Qty: 30.00	Days: 30	Refills: 0	PH/TH: RH Class: 0
Drug: CYCLOBENZAPRINE HYDR ER 15MG CAP			
Sig: TAKE ONE CAPSULE BY MOUTH DAILY AT BEDTIME			
Signature: [REDACTED]		Date: [REDACTED]	
This Prescription Will be Filled Generically Unless		N	
Prescriber Writes "DAW" in the Box		Dispense As Written	

<b>BRIARWOOD RX INC</b>		<b>BRIARWOOD, NY 11435</b>	
8515 MAIN ST			
Phone: (718)480-6740		Fax: (516)408-3992	
6/26/2020 11:16:01AM			
Rx Pres: ARKAM REHMAN		Ord Date: 06/17/2020	
3027 AVE V		NPI#: 1013920602	
BROOKLYN, NY 11229		LIC#: 298627	
Phone: (347)702-9725		DEA#: BR4816685	
Fax: [REDACTED]		SPE#: [REDACTED]	
Patient: [REDACTED]		[REDACTED]	
DOB: [REDACTED]	Gender: M	Rx#: 60435	
Address: 245 COZINE AVE APT 6F		BROOKLYN, NY 11207	
Phone: (347)744-2423		Qty Ord: 60.000	
Qty: 60.00	Days: 30	Refills: 0	PH/TH: RH Class: 0
Drug: MELOXICAM 15MG TAB			
Sig: TAKE ONE TABLET BY MOUTH TWICE A DAY			
Signature: [REDACTED]		Date: [REDACTED]	
This Prescription Will be Filled Generically Unless		N	
Prescriber Writes "DAW" in the Box		Dispense As Written	

78. The above prescription in paragraph 77 are a representative sample and are fraudulent in nature as I never prescribed the items to be dispensed nor did I sign or authorize the prescriptions.

79. To the best of my recollection the above prescriptions in paragraph 77 presented by Briarwood RX Inc. that is/are alleged to have been prescribed by me is/are fraudulent in nature as I never prescribed or authorized the item to be dispensed.

**Big Apple Medical Group Corp.**

80. I did not prescribe nor authorize a prescription for any durable medical equipment





Atlas Pharmacy, LLC

83. I did not prescribe nor authorize the prescription for any medication, creams, patches, or ointments as allegedly provided by Atlas Pharmacy, LLC as indicated below. The following prescriptions are also fraudulent in nature as I did not sign the prescription, I did not prescribe or request that the following medication be given to the patient:

Physician Order Form	
Patient Name: [REDACTED]	Physician Name: <i>Reem Rehman</i>
Date of Birth: [REDACTED]	License Number: <i>298624</i>
Telephone Number: [REDACTED]	NPI Number: <i>1013920602</i>
Date of Accident: [REDACTED]	
<input type="radio"/> CELEBREX 100MG - 1C BID #60 <input checked="" type="radio"/> CELEBREX 200MG - 1C BID #60 <input type="radio"/> CELEBREX 400MG - 1C QD #30 <input type="radio"/> MELOXICAM 7.5MG #60 1T BID <input type="radio"/> MELOXICAM 15MG #30 1T QD <input type="radio"/> IBUPROFEN 600MG #60 - 1T BID <input type="radio"/> NAPROXEN 550MG #60 - 1T BID <input type="radio"/> NAPRELAN 500MG #60 - 1T BID <input type="radio"/> LIDOCAINE 5% PATCH #30 #60 #90 APPLY 1-3 PATCHES AA QD (12 HOURS ON AND 12 HOURS OFF) <input type="radio"/> LIDOCAINE 5% OINT 100GM 150GM 200GM 250GM AP AA UP TO TID <input checked="" type="radio"/> DICLOFENAC 3% GEL - 100GM 200GM AP AA TID UD <input type="radio"/> CYCLOBENZAPRINE 7.5MG #90 - 1T TID <input type="radio"/> CYCLOBENZAPRINE 10MG #90 - 1T TID <input type="radio"/> TIZANIDINE 4MG #90 - 1T TID <input type="radio"/> METAXALONE 800MG #90 - 1T TID <input type="radio"/> FLORICET TABS #90 1T TID PRN <input type="radio"/> SUMATRIPTAN 25MG, 50MG, 100MG TABS <input type="radio"/> (MAXALT) RIZATRIPTAN 5MG, 10MG TABS <input type="radio"/> RELPAX 20MG, 40MG TABS <input type="radio"/> TOPIRAMATE 25MG, 50MG, 100MG <input type="radio"/> DULOXETINE 30MG, 60MG CAPS <input type="radio"/> GABAPENTIN 300MG, 400MG, 600MG, 800MG <input type="radio"/> VENLAFAXINE 25MG, 37.5MG, 50MG, AND 75MG TABLETS <input type="radio"/> SERTRALINE 25MG, 50MG, 100MG <input type="radio"/> ESCITALOPRAM 10MG, 20MG TABS <input type="radio"/> CHLORZOXAZONE 250MG #90 - 1T TID PRN	
Prescriber Signature: <i>[Signature]</i>	Date: <i>5/18/20</i>

84. The above physician order form in paragraph 83 is a representative example and is fraudulent in nature as I never prescribed the items to be dispensed nor did I sign or authorize the prescriptions.

85. The above-mentioned prescription in paragraph 83 presented by Atlas Pharmacy LLC that is/are alleged to have been prescribed by me is/are fraudulent in nature as I never prescribed or authorized the item to be dispensed.

AVK RX Inc.

86. I did not prescribe nor authorize the prescription for any medication, creams, patches, or ointments as allegedly provided by AVK RX Inc as indicated below. The following prescription is also fraudulent in nature as I did not sign the prescription, I did not prescribe or request that the following medication be given to the patient:

<b>AVK RX Pharmacy</b> 3904 Church Ave Phone: (718)484-9810 Fax: (718)484-8773 Print Date: 11/17/2020 5:41:23PM		Rx# 99353 11/17/2020 5:41:23PM Brooklyn, NY 11203
Rx Pres: Arkam Reisman 3027 AVE V BROOKLYN, NY 11229 Phone: (904)292-2700 Fax: (904)292-2666	Date: 11/10/2020 NPI: 1013920602 LIC#: 298627 DEA#: FR8864000	
Patient: [REDACTED] DOB: [REDACTED] Gender: F Address: 1410 ROCKAWAY PKWAY Phone: (616)573-4780 Qty: 60.000 (Sixty) Days: 30 Refills: 0 Filler: 1A (Last: 0 Qty Ord: 60.000)	BROOKLYN, NY 11236 Drug: LIDOTHIOL 4.5%/5% P/LM Sig: APPLY 1 PATCH TO AFFECTED AREAS TWICE DAILY	Pharmacy
Signature: _____ Date: _____ This Prescription Will be Filled Generically Unless Prescriber Writes "DAV" in the Box	N (U) Dispense As Written	

87. The above prescription in paragraph 86 is a representative example and is fraudulent in nature as I never prescribed the items to be dispensed nor did I sign or authorize the prescriptions.

88. To the best of my recollection the above-mentioned prescription in paragraph 86 presented by AVK RX Inc. that is/are alleged to have been prescribed by me is/are fraudulent in nature as I never prescribed or authorized the item to be dispensed.

A to Z Supply Services Inc.

89. I did not prescribe nor authorize a prescription for any durable medical equipment as allegedly provided by A to Z Supply Services Inc. as indicated below. The following prescription is also fraudulent in nature as I did not sign the prescription, I did not prescribe or request that the following equipment be given to the patient, nor did I agree with the Letter of Medical Necessity contained within the prescription:


Durable Medical Equipment Prescription

Patient Name: [REDACTED] Date of Prescription: 1-28-21

Patient Address: [REDACTED] Patient Tel: [REDACTED]

This is Diagnosis M23.90 Cervical Injury M99.01 Segmental And Sacral Pattern Dysfunction Of Cervical Region M99.02 Segmental And Sacral Dysfunction Of Thoracic Region M99.03 Segmental And Sacral Dysfunction Of Lumbar Region M54.11 R/O Cervical Radiculopathy M54.16 Lumbar Radiculopathy M54.17 Cervicalgia M54.26 Lumbar Disk Displacement M54.28 Shoulder Injury M54.49 Contracture Of Muscle Multiple Sites Z14.30A Cervical Spinal Stenosis Z14.50A Lumbar Spinal Stenosis M52.810 Muscle Spasm Of Neck M52.83 Contracture Of Muscle Multiple Sites M52.85 Cervical Disc Displacement M52.14 Lumbar Disk Displacement M83.509 Unspecified Sprain Of Unspecified Wrist Initial Encounter S93.409 Ankle Sprain M54.1 - Low Back Pain

<input type="checkbox"/> TLO Back Support	<input type="checkbox"/> Shoulder Support
<input type="checkbox"/> Lumbar Sacral Orthosis	<input type="checkbox"/> Shoulder Elbow Wrist Orthosis (R/L) MRI
<input type="checkbox"/> Lumbar Back Cushion	<input type="checkbox"/> Wrist Support (R/L)
<input type="checkbox"/> Cervical Collar, Semi-rigid	<input type="checkbox"/> Lumbar Sacral Orthosis MRI
<input type="checkbox"/> Cervical Traction w/pump MRI	<input type="checkbox"/> Elbow Support (R/L)
<input type="checkbox"/> Egg Crate Mattress	<input type="checkbox"/> Elbow Orthosis (R/L) MRI
<input type="checkbox"/> Bed Board	<input type="checkbox"/> Wheel Chair
<input type="checkbox"/> Heating Pad	<input type="checkbox"/> Cervical Pillow
<input type="checkbox"/> Cold/Hot Water Circulation Unit	
<input checked="" type="checkbox"/> EMS Unit 4 Lead	
<input checked="" type="checkbox"/> Massage	
<input type="checkbox"/> Orthopedic Car Seat	
<input checked="" type="checkbox"/> Infrared Heat Lamp	
<input checked="" type="checkbox"/> Whirlpool	
<input type="checkbox"/> Cone	
<input type="checkbox"/> Knee Support (R/L)	
<input type="checkbox"/> Knee Orthosis Fitted (R/L) MRI	
<input type="checkbox"/> Ankle Support (R/L)	
<input type="checkbox"/> Ankle Foot Orthosis (R/L) MRI	



3027 AVENUE V  
BROOKLYN, NY 11229

Doctor's Notes: Patient is to wear prescribed Durable Medical Equipment  
For a period of 4-6 weeks reevaluation at that time.

Additional notes (if necessary)

Letter of Medical Necessity

As the referring provider, I certify that the above-prescribed order for the above checked Medical Equipment are medically necessary based on my diagnosis and as part of my overall treatment plan for my patient, who is identified by the name at the top of this form. I have advised my patient that he/she had a right to choose the durable medical equipment (DME) supplier that provides the prescribed products pursuant to this order. By my signature, I am prescribing the items listed above.

Dr. Name: Alexander Rehman  
License Number: 298629

Dr. Signature: [Signature]  
NPI: 1013920602

90. The above prescription in paragraph 89 is a representative example and is fraudulent in nature as I never prescribed the items to be dispensed nor did I sign or authorize the prescriptions.

91. The above-mentioned prescription in paragraph 89 presented by A to Z Supply Services Inc. that is/are alleged to have been prescribed by me is/are fraudulent in nature as I never prescribed or authorized the item to be dispensed.

**ARS Medical Equipment Corp**

92. I did not prescribe nor authorize the prescription for any durable medical equipment as allegedly provided by ARS Medical Equipment Corp as indicated below. The following prescription is also fraudulent in nature as I did not sign the prescription, I did not prescribe or request that the following equipment be given to the patient, nor did I agree with the Letter of



Medical Necessity contained within the prescription:


**Durable Medical Equipment Prescription**

Patient Name: [REDACTED] Date of Prescription: 7/8/20

Patient Address: \_\_\_\_\_ Patient Tel: \_\_\_\_\_

Patient Diagnosis: M21.50-Knee Injury M99.01-Segmental And Somatic Dysfunction Of Cervical Region M99.02-Segmental And Somatic Dysfunction Of Thoracic Region M99.03-Segmental And Somatic Dysfunction Of Lumbar Region M54.12-R/O Cervical Radiculopathy M54.16-Latibul Radiculopathy M54.2-Cervicalgia M51.26-Lumbar Disk Displacement S40.20a-Shoulder Injury M63.49-Contracture Of Muscle Multiple Sites S13.4-YCA-Cervical Spinal Stenosis S13.5-YCA-Lumbar Spinal Stenosis M62.830-Muscle Spasm Of Back M63.49-Contracture Of Muscle Multiple Sites M50.20-Cervical Disc Displacement M50.26-Lumbar Disc Displacement S06.50a-Unspecified Spine Of Unspecified Waist, Initial Encounter S73.409-Ankle Spasm M54.5-Low Back Pain

<input checked="" type="checkbox"/> TLO Back Support <input checked="" type="checkbox"/> Lumbar Sacral Orthosis <input checked="" type="checkbox"/> Lumbar Back Cushion <input checked="" type="checkbox"/> Cervical Collar, Semi-rigid <input checked="" type="checkbox"/> Cervical Traction w/pump MRI <input checked="" type="checkbox"/> Egg Crate Mattress <input checked="" type="checkbox"/> Bed Board <input checked="" type="checkbox"/> Heating Pad <input checked="" type="checkbox"/> Cold/Hot Water Circulation Unit <input type="checkbox"/> EMS Unit: 4 Lead <input type="checkbox"/> Massager <input checked="" type="checkbox"/> Orthopedic Car Seat <input type="checkbox"/> Infrared Heat Lamp <input type="checkbox"/> Whirlpool <input type="checkbox"/> Cane <input type="checkbox"/> Knee Support (R/L) <input type="checkbox"/> Knee Orthosis Fitted (R/L) MRI <input type="checkbox"/> Ankle Support (R/L) <input type="checkbox"/> Ankle Foot Orthosis (R/L) MRI	<input checked="" type="checkbox"/> Shoulder Support <i>LT</i> <input type="checkbox"/> Shoulder Elbow Wrist Orthosis (R/L) MRI <input type="checkbox"/> Wrist Support (R/L) <input type="checkbox"/> Lumbar Sacral Orthosis MRI <input type="checkbox"/> Elbow Support (R/L) <input type="checkbox"/> Elbow Orthosis (R/L) MRI <input type="checkbox"/> Wheel Chair <input checked="" type="checkbox"/> Cervical Pillow <input type="checkbox"/> TLO Orthosis MRI
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**MEDICAL-CENTER**  
 3827 AVENUE V  
 BROOKLYN, NY 11229  
 MEDICALCENTERS@FONAL.COM  
 PHONE 0417703-9725  
 FAX 0417703-9721

**Doctor's Notes:** Patient is to wear prescribed Durable Medical Equipment for a period of 4-6 weeks reevaluation at that time.

Additional notes (if necessary): \_\_\_\_\_

**Letter of Medical Necessity**

As the referring provider, I certify that the above-prescribed order for the above checked Medical Equipment are medically necessary based on my diagnosis and as part of my overall treatment plan for my patient, who is identified by the name at the top of this form. I have advised my patient that he/she had a right to choose the durable medical equipment (DME) supplier that provides the prescribed products pursuant to this order. By my signature, I am prescribing the items listed above.

Dr. Name: Alexander Rehrman Dr. Signature: [Signature]  
 License Number: 298629 NPI: 1013922602

93. The above prescription in paragraph 92 is a representative example and is fraudulent in nature as I never prescribed the items to be dispensed nor did I sign or authorize the prescriptions.

94. The above-mentioned prescription in paragraph 92 presented by ARS Medical Equipment Corp that is/are alleged to have been prescribed by me is/are fraudulent in nature as I never prescribed or authorized the item to be dispensed.

**ASG RX, Corp.**

95. I did not prescribe nor authorize the prescription for any medication, creams, patches, or ointments as allegedly provided by ASG RX, Corp as indicated below. The following prescription is also fraudulent in nature as I did not sign the prescription, I did not prescribe or request that the following medication be given to the patient:



ASG Rx Corp 10216 Liberty Ave STE 101 Phone: (347)960-8788 Fax: (347)960-8755		Ozone Park, NY 11417	
Rx Pres: ARKAM REHMAN 1027 AVENUE V BROOKLYN, NY 11229 Phone: (347)702-9725 Fax:		Ord Date: 10/21/2020 NPI#: 1013920602 LIC#: 298627 DEAB: SPH:	
Patient: [REDACTED] NPI: 1013920602			
DOB: [REDACTED] Gender: M Race: 61558			
Address: 93 02 RIDGE BLVD APT 5E ARVERNE, NY 11209			
Phone: (347)335-8143 Qty Ord: 60.000			
Qty: 60.00 Days: 30 Refills: 0 PH/TB: UO Class: 0			
Drug: ESOMEPRAZOLE MAGNESIUM 20MG CAP			
Sig: TAKE ONE CAPSULE BY MOUTH TWICE A DAY AS NEEDED			
Signature _____ Date _____		This Prescription Will be Filled Generically Unless Prescriber Writes "DAW" in the Box <input type="checkbox"/> N	

ASG Rx Corp 10216 Liberty Ave STE 101 Phone: (347)960-8788 Fax: (347)960-8755		Ozone Park, NY 11417	
Rx Pres: ARKAM REHMAN 1027 AVENUE V BROOKLYN, NY 11229 Phone: (347)702-9725 Fax:		Ord Date: 10/21/2020 NPI#: 1013920602 LIC#: 298627 DEAB: SPH:	
Patient: [REDACTED] NPI: 1013920602			
DOB: [REDACTED] Gender: M Race: 61557			
Address: 93 02 RIDGE BLVD APT 5E ARVERNE, NY 11209			
Phone: (347)335-8143 Qty Ord: 250.000			
Qty: 250.00 Days: 30 Refills: 0 PH/TB: UO Class: 0			
Drug: LIDOCAINE 5% OINT			
Sig: APPLY TO AFFECTED AREAS 2-3 TIMES DAILY AS NEEDED			
Signature _____ Date _____		This Prescription Will be Filled Generically Unless Prescriber Writes "DAW" in the Box <input type="checkbox"/> N	

96. The above prescriptions in paragraph 95 are a representative example and are fraudulent in nature as I never prescribed the items to be dispensed nor did I sign or authorize the prescriptions.

97. To the best of my recollection the above-mentioned prescription in paragraph 95 presented by ASG RX, Corp that is/are alleged to have been prescribed by me is/are fraudulent in nature as I never knowingly prescribed or authorized the item to be dispensed.

### Conclusion

98. The preceding examples of prescriptions and/or order forms all as specifically noted in paragraphs 4, 6, 9, 12, 15, 18, 21, 24, 27, 31, 33, 36, 39, 42, 45, 48, 51, 54, 57, 59, 62, 65, 68, 71, 74, 77, 80, 83, 86, 89, 92 and 95 are examples of the fraudulent prescriptions that were issued utilizing my credentials. The absence of a specific prescription and/or order form that is not specifically noted in paragraphs 4, 6, 9, 12, 15, 18, 21, 24, 27, 31, 33, 36, 39, 42, 45, 48, 51, 54, 57, 59, 62, 65, 68, 71, 74, 77, 80, 83, 86, 89, 92 and 95 should not be inferred to be a legitimate prescription.

99. At no point in time while I and Apex was located at either 3027 Avenue V, Brooklyn, New York and/or 632 Utica Avenue, Brooklyn, New York did I ever issue any of the prescriptions as specifically noted in paragraphs 4, 6, 9, 12, 15, 18, 21, 24, 27, 31, 33, 36, 39, 42, 45, 48, 51, 54, 57, 59, 62, 65, 68, 71, 74, 77, 80, 83, 86, 89, 92 and 95 for any medication, creams, ointments, gels, patches, DME, MRI or any other matter. I also never knowingly issued, authored, or signed any letters of medical necessity pertaining to any of the aforementioned prescriptions or orders that were issued in my name.

